PO Box 186
Fortune, NL
A0E 1P0
unitedcommunitiescarefund@gmail.com

Application for Financial Assistance

Applicant Information:

Name:			
Mailing Address:			
Telephone:		**Cell:**	
Email:			
Preferred Method of Contact	**Email:**	**Phone:**	**Mail:**

Section two (2): Claimant Information

Does claimant have Health Insurance either through work or privately purchased (Blue Cross, Canada Life, Belairdirect, etc.
Yes No If Yes, name of Insurance Provider
***Medical Travel Expenses MUST be assessed by the private insurance provider prior to submitting a claim to the United Communities Care Fund**
Has claimant received a travel subsidy from another Government Department, Organization, Fundraiser or employer to help cover the cost of this trip?
Yes No If yes, Source **Amount:**
Is Claimant a subsidized Home Support recipient or in receipt of Income Support Benefits?
Yes No If yes, please contact Income Support Medical Transportation for more information about receiving medical travel assistance.

Section 3: Escort Information – An escort must be medically required and supported by medical documentation from a physician.

Last Name	**First Name**

Relation to Claimant : Parent Spouse Other

Section 4: Medical Travel Information. Complete all applicable sections. ONLY provide the information requested. Do NOT include any unnecessary personal information.

Trip Details:	
Date of Departure:	Date of Return:
Location of Appointment:	
Is this for Emergent/Critical Care: Yes No or Chronic Care: Yes No	

Section 5: Declaration of Eligibility for Medical Transportation Assistance – The declaration below must be signed by the claimant. Unsigned applications are considered incomplete and will be returned for a signature.

- I declare that the information provided on this application is true and correct to the best of my knowledge.
- I declare disclosure of **fundraising initiatives,** including any **GoFundMe** campaigns.
- I declare that financial assistance for medical travel was not provided by the Department of Children, Seniors and Social Development, Department of Health and Community Services, Workplace NL, or any other Federal/Provincial Government Department, Agency, Board, Commission, or NL Health Services.

I _____ hereby declare that I am the person named on this form and I am a resident of Point May, Fortune, Grand Bank or Grand Beach.

Claimant's Signature: _____

Date: _____

Section 6: Completed claims

The United Communities Care Fund – Board/Directors understands that individuals and families may require financial assistance more than once within a calendar year. To remain eligible for future assistance, please read and sign the declaration below.

I declare that I agree to provide proof of attendance and/or receipts, as applicable, to support this claim and any future claims.

Claimant's Signature: _____

Completed claims, along with the required supporting documentation and official receipts for eligible costs can be emailed to: unitedcommunitiescarefund@gmail.com

Alternatively, a claimant can mail their claim and supporting documentation to the following:

United Communities Care Fund
PO Box 186
Fortune, NL
A0E 1P0

For Office Use Only				
Expense Type	**Expense Date**	**Expense Amount**	**Receipt (s) Y/N**	
Airfare/Baggage				
Taxis				
Paid Accommodations				
Other medical expenses				
Meals				
Ferries/Buses				
	Total			
Private Vehicle Mileage				
Starting Location (City/Town/Facility)	**Ending Location (City/Town/Facility)**	**Dates of Travel**	**Round Trip**	**Distance Travelled (Total of both legs, if a round trip)**
			Total	